MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
JULY 11, 1997 STUDY SESSION NOTES

Friday , July 11, 1997
10:00am
225 South Airport Boulevard, Salon F
South San Francisco, California

I. CALL TO ORDER [Chairman] - 10:00am

The second Study Session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman Alain Enthoven, at the South San Francisco Conference Center.

The following members were present: Dr. Bernard Alpert, Mr. Rodney Armstead, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Mr. Terry Hartshorn, Mr. Bill Hauck, Mr. Mark Hiepler, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Mr. Allan Zaremberg, Mr. Steve Zatkin.

The following Ex-Officio members were present: Mr. Keith Bishop, Ms. Marjorie Berte and Dr. David Werdegar

II. OPENING REMARKS [Chairman and Executive Director] - 10:10am

Chairman Enthoven stated the focus of today's Study Session was Quality of Medical Care. He introduced the five speakers for the Study Session: Dr. Arnold Milstein, Dr. Robert Miller and Dr. Joseph Aita, Dr. Zwerner and Dr. Madvig and gave a very brief synopsis of their backgrounds. He then turned the meeting over to Dr. Phil Romero, Executive Director of the Task Force, to discuss a few administrative issues.

Executive Director Romero discussed several administrative issues including Task Force member meeting materials, the Expert Resource Groups, the Task Force meeting schedule and Task Force meeting locations. The following are comments made by several Task Force members regarding Executive Director Romero's remarks.

Ms. O'Sullivan stated that she felt the San Francisco meeting location was very inaccessible to public transportation. She also brought up the topic of how the Task Force members need to decide on priorities such as spending money on a more convenient meeting location or using that same money for other items such as public polling.

Mr. Romero responded to Ms. O'Sullivan's remarks by stating that staff had made significant efforts to find a suitable and inexpensive meeting location. Further, he suggested that members notify staff of any prospective meeting locations for future meetings.

Mr. Lee asked Executive Director Romero as to whether the co-chairs of the Expert Resource Groups were being noted on the materials that were being sent to the public and the Task Force members. He also asked the status of the legislation that was going to reimburse the Task Force members for their travel costs. Deputy Director Alice Singh responded by stating that the language that would allow the members to be reimbursed for travel will be taken out of AB 227 (Richter), but that a budget trailer bill was going through the process that incorporated the removed language and nothing could be determined about this until after a budget is passed.

Ms. O'Sullivan continued the Opening Remarks portion of the meeting by asking about the potential for the Task Force to be used as a tool to kill certain pieces of legislation, a fact that Ms. O'Sullivan felt they had been assured as members would not happen. Both Dr. Enthoven and Executive Director Romero reiterated to Ms. O'Sullivan that they both did not see any evidence of the Task Force being used for that purpose.

Ms. Finberg also spoke up on this subject asking if there was a way to reconfirm that indeed the Task Force would not be misused in regards to legislation. She felt strongly that policy and legislation go forward and that the recommendations from the Task Force be instrumental in shaping that policy.

Mr. Lee made the final suggestion that this issue be slated for discussion at the August 7 meeting in Los Angeles.

III. DISCUSSION - 10:25am

A. Quality of Care in Managed Care vs. Fee for Service Care

1. **Arnie Milstein, MD - Medical Director, Pacific Business Group on Health (PBGH).** Milstein began by stating that the health care industry has neglected to measure quality of care until very recently. He asserted that while America's best quality of care is probably second to none, our average quality of care is generally poor in relation to its cost. As managed care addresses costs by reducing service volume, we become more interested in measuring quality to assure ourselves that we are "only eliminating fat and not muscle."

Dr. Milstein then reviewed the findings of research comparing quality of care under managed care versus fee-for-service (FFS) systems. He declared that this research is ambiguous as to whether quality of care is improving or declining under managed care. He cited research that found that while the average patient fared better under managed care, the sicker and older subset of patients fared better under FFS. PBGH's research on quality at the medical group level found tremendous variation, with some capitated medical groups significantly outperforming FFS care and others performing significantly worse than FFS. He further described research by Dr. Eve Kerr that found that capitated medical groups 1) focused on detecting over-utilization rather than under-utilization of services and 2) emphasized preventive services rather than provision of services to the chronically ill.

Dr. Milstein recommended that we develop more comparative quality measures and quality accountability at each performance level (plan, hospital, medical group, and individual clinician). These quality measures need to be comprehensive, methodologically sound, user friendly, and public. The public and purchasers need to be educated in use of quality measures, and they need to incorporate the measures into their purchasing decisions. In the short term, we should expand the use of existing quality measures. In the longer term, we should build California's information system infrastructure to enable better, quicker, and cheaper quality measurement and accountability.

(Dr. Milstein then took questions from the members)

Q: Allen Zaremberg asked Dr. Milstein: How do you measure quality? Whose standards should quality be measured by? And, once you establish the first two questions, do you have the ability to accumulate this kind of data from a FFS delivery system?

A: Dr. Milstein felt that there are a variety of choices for quality measurement, from customer surveys to longitudinal studies of global health status. He stated that over time there will begin to be different definitions of quality depending on your perspective - for example, employers might be more interested in work force absenteeism than consumers are. He felt that as people become less willing to pay the price of unmanaged, FFS care, comparisons will have to be made between degrees of managed care rather than between managed care and FFS.

2. **Robert Miller, PhD - Associate Professor of Health Economics, Institute for Health Policy Studies, UCSF.** Dr. Miller outlined findings from a study that will be published in an upcoming issue of Health Affairs. His group analyzed evidence from 15 quality of care studies. They found equal numbers of statistically significant better and worse quality of care results for HMOs compared to non-HMO plans. He summarized this finding by stating that HMOs "produce better, same, and worse quality of care depending on the organization and the disease or condition." He stated that there is no pattern of worse quality of care under HMOs, but that some results are unfavorable to HMOs, particularly concerning care for patients with chronic conditions. He stated that these ambiguous results are inevitable due to perverse payment incentives, inadequate information, and very slow change in clinical processes.

A panel discussion was held with Task Force members and the two speakers.

Q: Mr. Rodgers asked if either doctor has seen an increase in investment in quality improvement information and, if so, where is that money coming from? Does government have a role in creating investment in the infrastructure or should it be strictly driven by the market?

A: Dr. Milstein felt that the investment has been quite small relative to the need. Dr. Miller felt that government should coordinate with various stakeholders to assess the costs and benefits involved and reach an agreement to push ahead.

Q: Mr. Zatkin asked the panel about quality outcomes and their relationship to various physician financial incentive arrangements.

A: Dr. Milstein felt that there was not very good information available on this subject, but that an analysis was set for release in August that would shed some light on this issue. He suggested that incentives should be more contingent on quality.

Q: Dr. Rodriguez-Trias asked about HEDIS and its use as an information tool. She also asked about establishing cause and effect relationships in intervention and using that information to measure quality.

A: Dr. Miller felt that many of the measures being used now are still very crude. Dr. Milstein stated that HEDIS 3.0 is a tremendous step forward but small in comparison to where we ought to be. He outlined two problems: 1) Our information systems are very scanty. 2) For most of what we do in medicine, we don't have good proof that it does improve health.

Q: Dr. Alpert asked the speakers how they reconciled their ambiguous results with the public outcry over managed care.

A: Dr. Miller responded that the "take-home message" of their presentations is that we currently have a fairly mediocre level of quality, with wide variation in that mediocrity. He stated that we have a duty to improve that quality and make it more uniform.

Q: Mr. Lee asked, given the decreasing enrollment in pure FFS plans, how useful the distinction is between HMOs and FFS.

A: Dr. Miller felt that the distinction is between capitated and non-capitated systems. He acknowledged that the distinction gets complicated because most medical groups are not completely capitated and do accept PPO enrollees.

Q: Mr. Hiepler asked if the panelists knew of any studies about patients' knowledge of how their doctor is paid. He also asked if any of their studies distinguish between the types of capitation, or if they simply compared capitated to non-capitated arrangements.

A: Dr. Miller had no information that indicates patients know how their doctor is paid. Dr. Milstein added that there isn't much information showing that doctors know whether any given patient is under a capitated arrangement. He referred to two studies that attempted to categorize medical groups by the types of capitation they received.

Q: Several Task Force members asked for clarification of the term "perverse incentives."

A: Dr. Miller clarified that he was talking about payments to the physician organization. In the case of a physician organization that is paid essentially a finite amount of money, regardless of their patients' characteristics: if the organization wants to do the right thing and improve care for people with particular (high cost) conditions, it runs the risk of attracting a disproportionate number of people with those conditions to the practice and thereby driving up costs. This could be "catastrophe for the organization."

Q: Mr. Zaremberg asked if and how risk adjustment might be moved forward.

A: Dr. Miller stated that risk adjusted capitation payments to plans only make sense if plans also risk adjust their payments to the physician organization. He stated that many health economists believe there are currently available risk adjustment schemes that should be put into place.

Q: Mr. Hartshorn asked if either speaker could suggest Task Force recommendations that would address quality assessment and improvement.

A: Dr. Milstein suggested greater support for quality-based reimbursement from plans to physician groups and hospitals, and from physician groups to individual physicians. He was optimistic that the market would eventually solve the problem itself. However, he suggested that there be a legislative failsafe mechanism in the event that the industry is unwilling to sufficiently invest in the information infrastructure.

Break 11:40am

A: Dr. Miller had a chance to respond to Mr. Hartshorn's question before the break as to what recommendations he would make to the Task Force. He stated that any recommendations should be made in consultation with the stakeholders. He indicated there should be targets for the kinds of quality outcome measurements. He also suggested that there should be information available at the medical group level.

3. **Joseph Aita, MD - Executive Vice President and Medical Director, Lifeguard.** Dr. Aita discussed the structure and business operations of Lifeguard, an open network model, not-for-profit HMO that uses FFS reimbursement rather than capitation. He stated that "value" should be defined as "the best achievable health of the community served for the cost." He felt that detecting variation was crucial to enhancing quality and value. Dr. Aita stated that medical groups that bear risk act as insurance companies and should be regulated as such. He also felt that capitation impedes access. He stated that Lifeguard and other similar minded managed care plans can and do enhance the health and health outcomes of their members through prudent, consistent use of measurement tools.

B. Managed Care Efforts to Continuously Improve Quality of Health Care

1. **Alan Zwerner, MD, JD - President and CEO, The Medical Quality Commission (TMQC).** Dr. Zwerner discussed TMQC, their Workplan, products, and services, and the people who sit on the TMQC board. He then described three TMQC initiatives to improve quality in managed care: medical group and IPA accreditation; independent research, including cooperative efforts with PBGH and California Health Decisions; and education. He also discussed TMQC's role in facilitating industry collaboration.

2. **Phil Madvig, MD - Associate Executive Director, Permanente Medical Group.** Dr. Madvig began by describing the Kaiser Permanente plan. He then discussed examples of quality improvement successes and failures. He also described the criteria his organization uses to target areas for quality improvement, and he described some of those quality improvement efforts. Dr. Madvig cautioned against over-emphasis on targeted quality outcomes because when you focus on those measures, you get improvement in those areas, but distract attention and resources from other areas.

A panel discussion was held with the members and the three panelists.

Q: Dr. Alpert asked Dr. Aita if Lifeguard had ever considered moving to for-profit status and if he though the Task Force should make any recommendations regarding tax status. Dr. Alpert also asked Dr. Aita if he thought most pre-authorizations could be handled electronically.

A: Dr. Aita replied that about 7 years ago there were discussions about moving to for-profit status, but they dismissed the option because they felt it would not have been in keeping with the plan's original mission. He felt that the Task Force should not address this issue because the public doesn't have strong opinions about it. He noted that physicians, on the other hand, are very interested in Lifeguard as a non-profit.

Dr. Aita stated that electronic medical records are essential to further improvement in managed care processes and costs.

Q: Ms. Finberg asked if the TMQC data is available to the public and for details on the accreditation process.

A: Dr. Zwerner stated that public access to accreditation findings (including disclosure of who sought accreditation) will be available in the near future. He also gave some figures regarding the accreditation process. About half the groups pass the accreditation process, one quarter get provisional accreditation, and the last quarter are not accredited but revisited after six months. Approximately 3% fail.

Q: Mr. Hiepler asked Dr. Aita if capitation has an impact on the doctor/patient relationship and if it affects either party's satisfaction levels. He also asked Dr. Zwerner to define the phrase "capitation done incorrectly."

A: Dr. Aita responded that satisfaction rested more on the lack of access outside of the capitated group than any limitation of care within the group. Dr. Zwerner described "incorrect capitation" as capitation of the individual physician - "when capitation becomes compensation."

Q: Mr. Zaremberg asked about process improvements plans have devised to achieve the goal of providing the right treatments as fast as possible in the best manner possible.

A: Dr. Aita described physician "gold carding" (physicians with a well-established history with the plan no longer need prior authorization) and use of physician practice pattern profiling.

Q: Ms. Severoni asked questions of each panelist: What tools would Dr. Madvig be using to bring his members' voice into the quality improvement issues and changes? How does Dr. Aita help his members understand the authorization process? Does Dr. Zwerner think the accreditation process should be mandated instead of voluntary?

A: Dr. Madvig stated that they haven't involved their patients enough. However, he stated that they use surveys and follow-up surveys to involve members in certain targeted areas. Dr. Aita replied that they do not intervene in the outpatient referral process at all. He stated that the authorization process is explained in a newsletter, in addition to the standard member materials. Dr. Zwerner stated that purchasers and enrollees should demand accreditation of provider organizations.

Q: Dr. Conom asked Dr. Madvig some questions regarding his presentation and some of his project results that he had shared. Dr. Madvig stated that he would need to get back to her with a response.

IV. ADJOURNMENT

Hearing no request for public comment, Chairman Enthoven adjourned the Study Session at 1:15pm. He also noted that a public hearing would be conducted at 2:00pm today.

Prepared by: Stephanie Kauss